ODS Community Dental Provider Handbook

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WELCOME TO OUR NETWORK OF MEDICAID (OREGON HEALTH PLAN) DENTISTS

Thank you for your participation in the ODS Community Dental Provider network. The services you provide improve members' health and help them to have healthy mouths and bodies.

The information in this handbook will help answer many of your questions about the ODS Community Dental Plan. We welcome your comments and suggestions to improve the handbook and make it your one-stop resource for provider information.

ODS Community Dental offers OHP Plus dental plans to members who live in the following counties. Dentists in other counties may participate in our Medicaid network and see patients from these counties who are assigned to ODS Community Dental:

Baker	Grant	Malheur	Union
Benton	**Gilliam**	Marion	Washington
Clackamas	**Harney**	Multnomah	Wallowa
Clatsop	Hood River	**Morrow**	Wasco
Crook	**Lake**	Polk	**Wheeler**
Deschutes	Lane	**Sherman**	Yamhill
Douglas	Linn	Umatilla	

ODS Community Dental is committed to providing you with the best possible service for information and eligibility, claims payment accuracy, timely claims processing and excellent customer service. We are here to help you via telephone, email or in person, or through our web-based tools and online service Benefit Tracker.

ODS Community Dental conducts dental workshops to bring you information on updates and changes. These workshops also provide an opportunity for you to ask questions and meet our team members. Provider Onboarding trainings are available at ODS-Provider-Onboarding.pdf (odscommunitydental.com). Important information is shared via our electronic newsletters through the year. Please ensure your email address is up to date.

We are always looking for dentists to participate in the ODS Community Dental network. If you know of a dentist who is interested, please contact us.

Again, thank you for your support and participation.

Sincerely,

Dr. Teri Barichello, DMD VP, Chief Dental Officer

COMMUNITY DENTAL MISSION STATEMENT

The mission of ODS Community Dental is to ensure our members have access to and receive quality dental services. We are a dedicated team that works collaboratively with our Medicaid partners to achieve the triple aim vision of reducing costs and improving health outcomes and patient experiences for our members. We embrace diversity, equity and inclusion as core values and a lens through which we conduct our daily work. We do this because we believe good oral health contributes to good overall health.

RULES FOR PARTICIPATING DENTISTS

Participating dentists agree to abide by the following rules of ODS Community Dental, in addition to the Oregon Administrative Rules (OARs) that govern the Oregon Health Plan (OHP). You can locate the following OAR rule books online at:

https://www.oregon.gov/oha/HSD/OHP/Pages/Policy-OHP.aspx

Oregon Administrative Rules

Oregon Health Plan (MCO and CCO) Program (division 141)

OHP Dental Services

OHP General Rules

Participating ODS Community dentists also agree:

1. To submit a completed ADA standard dental claim form to ODS Community Dental at no cost to the patient for all services whether there is a charge or not.
2. To accept the ODS Community Dental fee schedule benefit payments for services rendered as payment in full.
3. To keep accurate and complete financial and patient records in a manner that meets generally accepted practices.
4. To allow ODS Community Dental access at reasonable times and upon request to inspect and make copies of the books, records and papers of a participating dentist relating to the services provided to the members and to any payments received by the dentist from such patients.
5. To not charge the member an amount over the OHP fee listed for any procedure or for a non-covered service that is not funded by OHP unless the member signs the approved OHA financial waiver (found here) before the treatment is rendered. For more on waivers see Billing the member for non-covered services section
6. To submit claims using the service completion date (i.e., partials, dentures or crowns should not be billed unless stated).

7. To have the patient statement reflect the same billed charges as the amount submitted to ODS Community Dental. For example, if a discount is offered to a patient, the discount needs to be reflected in the claim submitted to ODS Community Dental.
8. If ODS fails to pay for covered healthcare services as set forth in the member contract, the member is not liable to the provider for any amounts owed by ODS Community Dental in accordance with the provisions of ORS 750.095 (2)
9. To provide accurate and complete information to ODS Community Dental.
10. To provide after-hours contact information to members for dental emergencies.
11. To maintain OHP participating status by complying with credentialing standards. Credentialing needs to be completed for all dental associates prior to rendering treatment to ODS Community Dental members.
12. To not bill the patient for the following types of items:
    - For covered services that were denied due to a lack of referral or provider error (e.g., required documentation not submitted, etc.).
    - For covered services that were denied because the member was assigned to another general dentist other than the one who rendered the services
    - For services that are covered by ODS Community Dental or OHP — this includes balance billing the member for the difference between the ODS Community Dental allowed amount and the provider's billed charges.
    - For broken or missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the member.
13. Hospital charges for services, supplies or additional fees charged by the dentist for hospital treatment are excluded.
14. Obtain primary insurance and third-party liability information from patients and report that information within thirty (30) days to ODS and the Oregon Health Authority. To report the information to OHA go to: Oregon Office of Payment Accuracy and Recovery Insurance Reporting Application - Home Page.
    - At a minimum the following information must be obtained:
        a. Name of third-party or in cases where the third-party payer has insurance to cover the liability, the name of the policy holder
        b. The member's relationship to the third-party payer or policy holder
        c. The social security number of the third-party payer or policy holder
        d. The policy holder's policy number
        e. The name and address of any third-party who paid the claim
15. **Dental Records Standards**

The provider is required to:

- Have all active dental records available for ODS Community Dental.
- Have a filing system that provides retrievable dental records.
- Maintain dental records for ten (10) years after the date of service for which claims are made.

16. Participating providers are required to release requested information to ODS Community Dental according to OAR 410-141-3520.

CREDENTIALING

Credentialing is the process of verifying elements of a licensed practitioner's training, experience, and current competence. Credentialing is a healthcare industry standard and helps ensure that ODS Community Dental members have access to a high-quality dentist within the ODS Community Dental provider network. The ODS Community Dental credentialing program is based on the standards of national, federal, and state accrediting and regulatory agencies.

We credential dentists when they join the ODS Community Dental provider network and every three years after that. Our process includes verifying credentials as well as reviewing and monitoring malpractice claims, state licensing disciplinary activity, and adverse outcomes.

We keep information provided during this process confidential. If we do not have your current credentials on file, we will pay the claim at the out-of-network level or may return it to your office.

Application elements that may be subject to verification:

- Current and past state license(s)
- DEA certificate
- Malpractice insurance coverage: ODS Community Dental requires a $1 million minimum per claim and a $3 million minimum aggregate amount for participation in our network
- Current practice information
- Work history, gaps in work history of two (2) months or more require explanation
- Dental or undergraduate education from an accredited school
- Malpractice claim history of last five (5) years, three (3) years for recredentialing
- Medicare/Medicaid sanctions/exclusions
- State license sanctions of last five (5) years, three (3) years for recredentialing
- Additional administrative data relating to a provider's ability to provide care and service to ODS

Community Dental members

17. National Provider Identifier, type 1- Individual

Discrepancy in credentialing information

When we find information that differs substantially from the information you submitted, we may require an explanation.

- We will notify you in writing of the discrepancy and request a written explanation within seven (7) calendar days. Our dental director or the peer review committee will review the explanation.
- If you do not respond within seven (7) calendar days, our credentialing supervisor will contact you by telephone to request a written response within seven (7) calendar days.
- If we do not receive a response, your application will be terminated, and you will be notified via certified letter.

Our Credentialing staff will process your application by verifying the information and will contact your office if additional information is needed. Once the verification is complete, the supervisor, dental director and/or peer review committee will review the application for any concerns and will determine if you will be credentialed as a participating dentist.

While participating with ODS Community Dental, dentists must maintain all licenses, registrations, certifications, and accreditations required by law. You must promptly notify ODS Community Dental in writing of any formal action against your licenses or, if applicable, against any certifications by certifying boards or organizations. You must notify ODS Community Dental of any changes in practice ownership or business address, along with any other facts that may impair your ability to provide services to ODS Community Dental members.

You have the right to:

- Appeal an ODS Community Dental decision to restrict, suspend or take other adverse action against your participation status.
- Not be discriminated against based on your race, ethnic/national identity, gender, age, sexual orientation, or types of procedures performed, legal under U.S. law, or patients in whom the provider specializes.
- Review information obtained by ODS Community Dental to evaluate the credentialing application. We will not share information that is peer-protected and protected by law.
- Correct erroneous information discovered during the verification process.
- Request, from the credentialing department, the credentialing application status via telephone, email or correspondence.

- Withdraw the application, in writing, at any time.
- Have the confidentiality of the application and supporting documents protected, and the information used for the sole purpose of application verification, peer review and panel participation decisions.
- Be notified of these rights.

To find an electronic version of the dental credentialing and credentialing applications visit our website: Credentialing (odscommunitydental.com)**You can send your application and materials by:**

Mail: Moda Health Attn:
Provider Credentialing – 8th Floor,
601 S.W. 2nd Avenue, Portland, OR 97204 Fax: 503-265-5707
Email: credentialing@modahealth.com

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THE PRIORITIZED LIST OF HEALTH SERVICES

The Oregon Health Authority maintains a list of condition and treatment pairings known as the Prioritized List of Health Services. These pairings have been ranked by priority from most important to least important and subsequently assigned a line number. Services prioritized as most important are funded by the state. The funding level is set at a line designated by the state. This means any pairing that occurs above the line is considered funded. Any pairing that occurs below the line is not funded. Below-the-line services include treatments that do not have beneficial results, treatments for cosmetic reasons and conditions that resolve on their own. ODS Community Dental covers all funded dental services.

Resources

To verify whether a dental service is covered by ODS Community Dental, and to find

out where the OHP line is currently set, check the Prioritized List of Health Services.

To find the Prioritized List You may also Search the list

Refer to the ODS Community Dental list of covered and non-covered services located on

Benefit Tracker and at www.odscommunitydental.com.

Important to know

- Due to legislative decisions, the funding line is subject to change. For the most current information, be sure to check with the Oregon Health Authority or ODS Community Dental.
- Treatment may be covered for one condition but not covered for another. Remember that the pairing of the condition with the treatment determines which line the service is on.
- If the service is not covered by ODS Community Dental but treatment is deemed essential, additional information such as chart notes, narrative and any related X-rays can be submitted to ODS Community Dental at https://www.at, https://www.odscommunitydental.com/providers/resources/dental-provider-correspondence-request-formDental odscommunitydental.com/providers/resources/dental-provider-correspondence-request-form
- (refer to https://sos.oregon.gov/Pages/index.aspx for the current OAR)
- Referral forms located at www.odscommunitydental.com

SERVICES COVERED BY ODS COMMUNITY DENTAL

Dental benefits are included in the Oregon Health Plan benefit package for all eligible members. Covered services include emergency services, preventive and restorative dentistry, extractions, and dentures and partials. Root canal therapy on first and second molars are a benefit for members under the age of 21 and on first molars for pregnant members (final restoration must be a covered benefit).

The benefit packages are designed for members under the age of 21, members over the age of 21, and pregnant members. For a detailed list of covered services broken down by age and pregnancy status, refer to the ODS Covered and Non Covered Services List. This list will also provide details regarding frequency and benefit limitations and recommendations for submitting a pre-determination of services.

Visit the ODS website at odscommunitydental.com/providers/referrals
for additional information about benefits, predeterminations, and provider correspondence.

If your patient needs assistance with the OHP application process, they can visit OHP.Oregon.gov and click on Apply for OHP.

TELE-DENTISTRY SERVICES

ODS Community Dental does not reimburse for tele-dental services provided via unsecure transmission methods such as Skype or FaceTime. Tele-dental services must be compliant with all applicable laws regarding privacy and security of members' Protected Health Information (PHI). This requirement does not apply during a state of emergency, as allowed by state and Federal law.

SERVICE LIMITATIONS AND EXCLUSIONS

In addition to service limitations listed in the OHP coverage list the following limitations and exclusions apply:

- Services for injuries or conditions that are compensable under worker's compensation or Employer's
- Liability Laws are excluded.
- Procedures, appliances, restorations, or other services that are primarily for cosmetic purposes are excluded.
- Experimental procedures or supplies are excluded.
- Dental services started prior to the date the individual became eligible for such services under the OHP contract are excluded.
- Any services related to the treatment of TMJ are excluded.
- Claims received later than four months from the date of service shall be invalid, not payable, and not billable to the member.
- Claims that meet the criteria outlined in OAR 410-141-3565 and must be submitted within 120 days from the date of service, unless qualifying exceptions apply, or they will be invalid and not payable.
- Exclusions include all other services or supplies not specifically included in the OHP Plus Fee Schedule.

BILLING THE MEMBER FOR NON-COVERED SERVICES

State and federal regulations prohibit billing OHP members for OHP covered services. You must inform OHP members of any charges for non-covered services and provide them with their appeal rights prior to non-covered services being rendered.

When a member chooses to receive a specific service that is not covered by ODS Community

Dental, you must document this using the Oregon Health Authority/Oregon Health Plan Client Agreement to Pay for Health Services (OHP 3165 form), and the agreement must be physically signed by both the member and provider (stamped signatures are considered invalid) prior to rendering non-covered services. This agreement is valid only if the estimated fees do not change and the service is scheduled within 30 days of the member's signature. A sample of this OHA approved form has been included in the back of this handbook for your convenience. A copy of this form can also be downloaded here from our website. You are required to:

- Inform the member that the service is not covered
- Provide an estimate of the cost of the service
- Explain to the member their financial responsibility for the service
- Complete the OHA OHP Client Agreement to Pay for Health Services (OHP 3165 form) located in the back of this handbook.
- Make arrangements with the member prior to rendering the service
- Complete the agreement in the primary language of the member

A brief listing of non-covered ODS Community Dental services includes the following:

- Fixed prosthodontics
- Retreatment of previous root canal therapy to bicuspid and molars
- Veneers
- Implant and implant services
- Teeth whitening and other cosmetic procedures or appliances

For a list of allowed CDT codes and fees, contact dental professional relations at 503-265-5720, 888-374-8905 or dpror@deltadentalor.com. A complete CDT list with fees and frequency limitations is also available by selecting the OHP Covered/Non-Covered Services link in Benefit Tracker.

For a complete description of the rules, please refer to the Oregon Secretary of State Administrative Rules

OVERPAYMENTS

When your office determines that you have received an overpayment on one of your patients, please include, a check for remittance of overpayment and the following information:

- Patient name
- Member identification number

- Date of service
- Claim number (if known)
- Reason for refund or a copy of the letter if you have received a refund request letter for ODS Community Dental

You may also use the "Provider Refund Submission Form" located under "Provider Resources" on the ODS Community Dental site. Simply print the form, fill in the appropriate information and mail the form with your refund to the address shown on the bottom of the form.

Recovery of overpayments to providers

If ODS Community Dental does not receive payment within 90 days of a written request, then we may deduct the amount you owe from the amount that is due to you on your next claim(s).

Non-emergent medical transportation (NEMT) is available to patients who do not have other means to travel to and from their dental appointments. This is a benefit provided to an OHP member by their coordinated care organization (CCO), or directly by the state if the member is not enrolled in a CCO. An OHP member requesting transportation assistance should call the phone number designated by their CCO, as listed in the chart below.

THE OREGON COORDINATED CARE MODEL

The majority of all OHP members are assigned to a local coordinated care organization (CCO). CCOs are a network of all types of providers (physical health, behavioral health, and oral health) committed to coordinate care for their patients and in doing so, improve the health of Oregonians. CCOs partner with providers, members, and community organizations to identify social needs and overall health needs in an effort to deliver member centric integrated care with a focus on prevention and member education.

For additional information about CCOs visit the OHA site at at
www.oregon.gov/oha/hsd/ohp/pages/coordinated-care-organizations.aspx

There is a total of 15 CCOs in Oregon. ODS Community Dental has partnered with the following 10 CCOs:

CCO	General Contact	Transportation Contact	Counties Served
Columbia Pacific CCO	800-224-4840	NW Rides 888-793-0439	Clatsop, Columbia, and Tillamook
Eastern Oregon CCO	888-788-9821	Free Ride Program 877-875-4657	Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler
Health Share of Oregon	888-519-3845	Ride to Care - 855-321-4899	Clackamas, Multnomah, and Washington
InterCommunity Health Network CCO	800-832-4580	Cascade Ride Line 866-724-2975	Benton, Lincoln, and Linn
Jackson Care Connect	800-224-4840	TransLink 888-518-8160	Jackson
PacificSource Community Solutions – Columbia Gorge	800-431-4135	LogisitCare 855-397-3617	Hood River and Wasco
PacificSource Community Solutions – Central Oregon	800-431-4135	LogistiCare 855-397-3619	Crook, Deschutes, Jefferson, and Klamath
PacificSource Community Solutions – Marion and Polk	800-431-4135	LogisitiCare 844-544-1397	Marion and Polk
PacificSource Community Solutions – Lane County	800-431-4135	RideSource 877-800-9899	Lane
Trillium Community Health Plan	877-600-5472	RideSource 877-800-9899 MTM (tri-county) 877-583-1552	Benton, Lane, Linn, Clackamas, Multnomah, Washington, and Douglas

INTERPRETER AND TRANSLATION SERVICES

All contracted ODS Community Dental OHP providers must make interpretation services available to ODS Dental members at no cost to the member. Interpretation must be available during and after hours for consultation, appointment scheduling, and provision of care. ODS coordinates interpretation services for members' dental appointments for covered services through our preferred vendor, Passport to Languages Interpretation should not be provided by a member of the patient's family.

In order for bilingual staff members to provide interpreter services, they must be OHA certified or qualified. In order for bilingual dentists to provide services in member's preferred language, they must pass a proficiency test. ODS offers financial assistance for certification training and proficiency testing. For additional information, contact ODS as odslangaccess@odscommunitydental.com.

ODS coordinates interpretation services for members' dental appointments for covered services through our preferred vendor, Passport to Languages. To arrange for an interpreter to be present during an appointment there are several options:

- **Call**:
    - Passport to Languages at 503-297-2707 (800-297-2707) at least two business days before the appointment.
- **Fax** your completed ODS Interpreter Request form to Passport to Languages at 503-297-1703 at least two business days before the appointment.
- **Email** the completed ODS Interpreter Request form (available on the Provider Forms and Procedures page of our website at https://www.odscommunitydental.com/providers/resources/interpreter-request-form) Once completed and submitted the request will be forwarded to Passport to Languages.
- **Place your order online** with Passport to Languages' online portal. Passport to Languages Customer Service staff sends a fax or email to the provider's office to confirm that interpreter arrangements are complete. To establish an online account contact ODS OHP Coordinators at 844-274-9124 for assistance in setting up your account.

For urgent needs (less than 48 hours' notice), call Passport to Languages Customer Service department at 503-297-2707 to arrange for an interpreter.

ODS Community Dental OHP providers can choose to coordinate interpreter services themselves rather than coordinating them through Passport to Languages; however, the provider will be responsible for paying for the interpreter services. ODS only pays for interpretation services for eligible ODS members that are coordinated through our preferred vendor, Passport to Languages. For audit purposes by OHA when an outside interpreter service is used, the dental office needs to ensure the following is included is documented for each visit:

- Name of the vendor used
- Name of interpreter
- Interpreter's OHA certified or qualified status (if any)

INTERPRETER REPORTING

Beginning in 2023, ODS will be outreaching to providers on a bi-annual recurrence requesting information regarding interpreters assisting ODS members. The reports are part of the monitoring requirements from OHA. One a bi-annual recurrence, ODS will send a list to provider offices for recently treated members who have been identified by OHA as needing interpreter services. For each appointment the member was seen, the OHA is requesting the following information (responses to questions are required unless indicated as optional):

    - Provider Group Name (Pre-populated)
    - Address of Service (Pre-populated)
- Interpreter service type (must answer all three with Yes or No. More than one response is acceptable)
    - In-person Interpreter Service (applies to interpreter from an agency or bilingual staff)
    - Telephonic Interpreter Service
    - Video Remote Interpreter Service
- Was the Interpreter OHA Certified or Qualified? Must select Y or N
- Interpreter's OHA Registry Number-Insert interpreter name if registry number is unknown
- Did bilingual dentist provide services in member's preferred language-Must select Y or N
- Did bilingual dentist pass a proficiency test? Must answer Y or N
- Did the member refuse Interpreter Service?
    - Answer Yes if-bilingual dentist provided service in member's preferred language

        - Answer Yes if-interpreter services were offered, and member refused
    - Answer No if-member accepted interpreter services from agency interpreter or bilingual staff Reason for Member Refusal (Optional but response would be appreciated)
        - Select response from drop down list
    - Notes from Clinic (Optional)
        - Insert any relevant notes related to this member's appointment

Questions regarding the report may be sent to the ODS Language Access team at odslangaccess@odscommunitydental.com.

I SPEAK CARDS

ODS Community Dental acknowledges that difficulties with communication can limit access to health care services for deaf and hard of hearing individuals and those with limited English proficiency (LEP). Through various initiatives, ODS continues to ensure this member population receives verbal, written and digital information in their preferred language and appropriate format.

A recent program is the release of member "I Speak" cards. These pocket-sized cards are available to members and can be presented at medical and dental appointments when interpreter services are needed.

Click **here** to order your "I Speak" packet. The packet includes "I Speak" cards in all prevalent languages, an informational flyer, and a card and flyer holder.

These are provided free of charge to our ODS providers.

Contact the ODS Language Access team at **odslangaccess@odscommunitydental.com** with questions.

TRANSLATION SERVICES

ODS Community Dental continues to work closely with dental offices ensuring all members receive information in a format that is easily understood and in the appropriate language for our members. If a dental office has patient forms that need to be translated into alternate languages, please contact the ODS Language Access team at odslangaccess@odscommunitydental.com.

SECOND OPINIONS

ODS Community Dental provides for a second opinion by a qualified dental provider for members at no cost. A provider within or outside the members plan can provide a second opinion by provider or member request.

A dental second opinion is defined as a patient privilege of requesting an examination and evaluation of a dental health condition by the appropriate qualified healthcare professional or clinician to verify or challenge the diagnosis by a first healthcare professional or clinician.

The member or provider (on behalf of the member) contacts ODS Community Dental to request a referral for a second opinion. ODS Community Dental reviews the request according to its referral processing guidelines and assists the member or provider to locate an appropriate in-network provider for the second opinion. If no appropriate provider is available in-network, a provider outside of the OHP network may be utilized but requires DMAP approval prior to services.

The requesting provider may call 800-342-0526 or fax the completed referral

request form to 503-952-5259.

DENTAL CASE MANAGEMENT

The ODS Community Dental Case Management team works closely with members, providers, and coordinated care organizations (CCOs) to ensure that our members who need additional support in accessing dental services receive the care they need.

We do this by:

- Coordinating specialty dental services for members with special needs
- Providing educational materials, follow-up, and reminder letters that are culturally and linguistically appropriate and specific to members' medical conditions
- Working with providers and CCO case management to coordinate care for members
- Making sure children newly placed in foster care receive an oral health assessment
- Addressing the need for ongoing preventive dental services for members of all ages

- Actively work to meet OHA and CCO measures of dental utilization

For more information on our dental case management services, please refer to our dental case management policy on the ODS Community Dental website. If you have a patient who needs additional support, please contact ODS Community Dental Customer Service at 800-342-0526.

DENTAL QUALITY METRICS

To serve dental Medicaid members throughout the state of Oregon, ODS has entered in CCO agreements with seven coordinated care organizations. These CCO partners hold ODS responsible for meeting OHA defined measures and CCO defined measures. We are also asked to meet targets for incentive measures, participate in a variety of CCO and OHA oral health/overall health initiatives and implement OHA compliance requirements. ODS shares bonus dollars received to Dental Offices who assisted in treating members to achieve the metrics. The following are 2023 metrics for ODS:

1. Tobacco Cessation-Dental Practice will report tobacco cessation efforts to ODS. Efforts include implementation of a culturally responsive and linguistically appropriate tobacco cessation program, billing tobacco cessation CDT code D1320 as applicable, and following the guidelines outlined in the ODS provider handbook relating to tobacco cessation.
2. Pregnant Members-Dental Provider will make their best effort to schedule a dental visit with their pregnant members within 280 days preceding delivery within 2023. ODS will provide pregnant member information as received by CCO partner.
3. Dental Practice will conduct risk assessments as appropriate and submit assessment codes D0601, D0602, and D0603. ODS recommends provider participation in the Health through Oral Wellness program. This risk assessment tool is offered to providers at no cost and provides custom educational materials based on the members risk scores.
4. Dental Practice will assist ODS dental case management with inquiries regarding their provision of interpreter services to for deaf and hard of hearing individuals and those with limited English proficiency (LEP).
5. DHS assessments-Dental Practice will schedule assigned members for an oral health assessment as requested by ODS dental case management.
6. Third Next Available Appointment Survey (TNAA)-Dental Practice will complete TNAA survey as required by CCO partner and administrated by ODS. Dental Practice will strive to meet defined access standards. If Dental Practice is found to be out of compliance, they will submit their plans and strategies for compliance to ODS Quality team.
7. Workforce training-Dental Practice staff will attend cultural competency training and other required training as defined by CCO partner.
8. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)-
    a. EPSDT: Effective January 1, 2023, members under age 21 are eligible for dental services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. This benefit provides

medical appropriate and medically necessary comprehensive and preventive health care services for children under the age of twenty-one who are enrolled in Medicaid.

b. Ortho treatment related to handicapping malocclusion: This treatment falls under the EPSDT benefit. ODS is in the process of developing a guidance document that will be shared with contracted ODS OHP providers. The guidance document will align with the OHA's requirements for case review, approval, treatment, and reimbursement.
c. For additional details regarding the EPSDT benefit, visit the OHA website at https://www.oregon.gov/oha/HSD/OHP/Pages/EPSDT.aspx

9. Health Information Technology (HIT): Dental Practice will review materials provided by ODS and respond to survey questions and consider participation in pilot programs regarding electronic health record (EHR), community information exchange (CIE) such as the Connect Oregon platform, and health information exchange (HIE).

THE REFERRAL PROCESS

For general dentists

You do not need a written referral to make a referral to a specialist. If you are requesting a referral for oral surgery, endodontics, pediatric dentistry, or denturists please have your office contact ODS Community Dental Customer Service at 800-342-0526 for names of specialty providers. You can also search Find Care on our website for a specialist in your area.

For patients with special needs, periodontal needs or when a second opinion is needed you do need to submit a written referral form request. You can fax the completed request to 503-952-5259 or complete form online at: https://www.odscommunitydental.com/providers/resources/referral-form.

For capitated providers

If you are requesting a referral for oral surgery, endodontics, pediatric dentistry, or denturists please have your office contact our ODS Community Dental Customer Service at 800-342-0526. Your office must send a referral request to ensure appropriate claims processes for the specialty office.

Referral requests must include:

- All pertinent patient information
  (name, ID number, birth date, medical concerns, etc.)
- Procedure that is being requested.
- Provider contact information, including mailing address
  and a return fax number, when applicable.

ODS Community Dental notifies the general dentist within 10 working days of receiving the request if the referral is approved, denied, or pending for further review. Urgent referrals are

processed within 1–2 working days.

Once the referral is approved, ODS Community Dental documents in the member record the specialist the member was referred to.

If the referral request is denied, a formal written denial is mailed to the member and to the general dentist providing reason for denial. The notification includes the reason for denial and the member's right to appeal the denial. Referrals are not a guarantee of payment.

Referral process for specialists

- Specialists must check eligibility before seeing a patient, regardless of the origin of the referral. The patient must be eligible with ODS Community Dental on the date of service.
- Specialists requesting additional follow-up visits or wishing to send a patient to another specialist for consultation or treatment must consult with the patient's general dentist.

Referrals are not a guarantee of payment.

ELIGIBILITY

The Oregon Health Authority reviews eligibility requirements for all OHP members, and once the member is enrolled, they can choose a dental carrier or may be assigned to a carrier through their coordinated care organization. The provider must verify that the individual receiving dental services is an eligible individual on the date of service for the service provided and that ODS Community Dental is the dental plan responsible for reimbursement. The provider assumes full financial risk of serving a person who isn't eligible for the service provided on the date of service. (OAR 410-141-3565).

ODS Community Dental recommends that the provider always make a photocopy of the member's Medicaid ID card and photo identification for the patient each time they present for services.

Oregon residents can seek assistance with Medicaid enrollment through the federal health insurance exchange at HealthCare.gov. Oregon residents can also call 1-855-CoverOR for a list of people in the member's area who can assist. This assistance is free.

Verifying member eligibility — online

There are two online systems available for verifying ODS Community Dental Oregon Health Plan member eligibility and benefits. Health Systems' MMIS will display member's eligibility and CCO contact information (but not which DCO the member is assigned to) and the ODS Community Dental Benefit Tracker will display eligibility information for our active dental members in all our partnered CCOs.

Medicaid Management Information System (MMIS)

MMIS provides a 24-hour, 7-days-a-week access for eligibility from Health Systems. MMIS will require a PIN issued by Health Systems for you to access information. For more information on MMIS, please visit https://www.or- medicaid.gov/ProdPortal/.

ODS Community Dental providers who are not contracted directly with the State for fee-for-service reimbursement should confirm MMIS access with Health Systems.

Verifying member eligibility — telephone

ODS Community Dental Customer Service staff uses Health Systems' MMIS system and Benefit Tracker to provide up-to-date information and policies so you can be confident you will receive the most current information available. You can reach us at 800-342-0526 from 7:30 a.m. to 5:30 p.m. Pacific Time, Monday through Friday, excluding holidays.

Due to HIPAA privacy rules, we require the following prior to verifying information about a member. Under OHP, each member has a separately assigned ID and a separate record.

Office information:

- First name of caller
- Provider's last name or clinic/provider office name
- Provider TIN
- Office phone number

Member information:

- Member recipient ID number*
- Member last name and first name
- Member date of birth

*If you don't know the member ID, please be prepared to provide the member Social Security Number (SSN) and member address.

Verifying member eligibility — email and fax

Email

You can email ODS Community Dental Customer Service at dentalcasemanagement@modahealth.com. You will need to identify yourself, as explained above, your patient and your request. Our goal is to send a response within 24 hours Monday through Friday, excluding holidays.

Commented [JG2]: Update email address to ODSCD?

Fax

You can fax ODS Community Dental Customer Service at 503-952-5259. You can fax a list of ODS Community Dental members including the member's first and last name, member ID and the member's date of birth. ODS Customer Service will use Health Systems' MMIS system, CCO web portals and Benefit Tracker to verify the member's eligibility. Faxes received by 3 p.m. will be returned no later than 9 a.m. on the following business day.

PLEASE NOTE: ODS Community Dental receives daily eligibility updates, and these will be reflected in the Benefit Tracker system. Whatever option you choose, you should also obtain a photocopy of the member's ID card and photo ID for each visit.

BENEFIT TRACKER (BT)

Benefit Tracker (BT) is a free online service designed especially for dental offices that allows dentists and designated office staff to quickly verify dental benefits, claims status information and patient eligibility directly from ODS Community Dental.

There are many benefits to using Benefit Tracker:

- Locate benefit information, including determining the type of plan a member is enrolled in.
- Access the most up-to-date information at the most convenient times for you, whether it's duringoffice hours or after hours.
- Quickly determine the best treatment plan for your patient based on benefit information.
- Keep track of the latest claims status of a patient or use the search filters to find the status of older claims.
- Print hard copies for patient files, treatment plan presentations and easy updates to plan benefit software.
- Common preventive services box. Displays whether or not a member is eligible for cleaning (prophylaxis), exam, bitewing radiographs, and full mouth series or panoramic radiographs. If the benefit is currently not available Benefit Tracker will display the next available date for theservice.

Benefit Tracker contact information

To register contact our Benefit Tracker Administrator:

Mail: Benefit Tracker Administrator 601 SW Second Ave.
Portland OR 97204
877-337-0651

Email: ebt@modahealth.com

For more information see our website.

ODS COMMUNITY DENTAL ID CARDS

Members receive an OHP ID card at their initial enrollment. Once enrolled in a CCO, they will also receive a CCO ID card. The CCO ID card indicates the member's dental plan assigned by the CCO. ODS does not issue a separate ID card for CCO members. The CCO issued ID card does not indicate if an ODS member has been assigned to a dentist, it will only display the dental plan. Contact ODS dental customer service or check Benefit Tracker to verify member's eligibility and possible provider assignment.

Assigned dentists

ODS members who are assigned to a specific dentist or office must seek treatment from that dentist for their benefits to be paid. If a patient seeks treatment from you, and you are not their assigned dentist, please direct the member to seek treatment from their assigned dentist. You can identify members who are assigned to a specific dental office on the Benefit Tracker under "Group Limitations."

Exceptions

If the member who has been assigned to a specific office travels outside of the service area and experiences a dental emergency, you can treat the member to relieve pain and for the dental emergency. However, upon treatment completion for the dental emergency or pain relief, refer the patient to their assigned dentist for follow- up and future dental care.

In non-emergency cases, members need a referral to a specialist or an out-of-network provider before we will issue payment to that provider. If you need to refer a patient to a specialist or another provider, please call our customer service department at 800-342-0526 or email dentalcasemanagement@modahealth.com for assistance.

HEALTH THROUGH ORAL WELLNESS PROGRAM

When it comes to oral health, we know some people need more care than others. ODS Community Dental's Health through Oral Wellness program offers extra benefits to members who have a greater risk for oral diseases.

To help your high-risk patients get the extra dental benefits and related care they need, you must be signed up for PreViser™, a third-party dental risk and periodontal disease application. Just follow these

steps to get started:

1. Sign up at my.previser.com/signup/ddor
2. Complete the request fields and click Register
3. You will receive an email from PreViser asking you to validate and complete your registration by going to previser.com and selecting 'My Account'. Click the link provided in the email to "activate" your account

By registering for PreViser, you will be able to conduct clinical risk assessments on ODS Community Dental (OHP) patients. ODS Community Dental members may now qualify for additional benefits if they score 3+ on their clinical risk assessment. Below is the enhanced benefits grid that details what benefits your patients may be eligible for based on their risk scores.

Enhanced plan	Risk levels	Enhanced benefit	CDT codes	Frequency
High-risk: Decay/Gum Disease	Tooth Decay/Risk Score (3+) or Gum Disease Risk Score (3+) or Gum Disease Score (4+)	Prophy or periodontal maintenance	D1110, D1120, D4346, D4910	Combination up to 1 per 3 months
		Fluoride varnish or topical fluoride	D1206, D1206	Combination up to 1 per 3 months
		Sealants	D1351	Once per 2 years
		Oral hygiene instruction or nutritional counseling	D1330, D1310	Once per 12 months
		Drugs or medicaments dispensed in the office for home use	D9630	Once per 6 months

ODS Community Dental members already receive benefits for all levels of oral cancer risk.

We encourage you to assess oral cancer risk as an educational opportunity for patients. After completing the assessment and receiving your patient's scores from PreViser, you may confirm their eligibility in Benefit Tracker and inform them about their enhanced benefits.

Billing reminder: a caries risk assessment is covered once every 12 months. Submit risk assessment code D0601, D0602, or D0603 on the claim form to receive reimbursement.

TIMELY ACCESS

To ensure that ODS Community Dental members have access to high-quality service and dental care in a timely manner, we are required to follow Oregon Administrative Rule access standards. We use the ODS Community Dental, third next available appointment survey, after-hour's access survey and member complaints to assess how well we are complying with the standards.

A. Telephone triage for appointment scheduling
Members calling to request dental care are assessed to determine if the level of care required is emergent, urgent, or routine.

1. When members request an appointment, the receptionist/scheduler asks questions to determine the urgency of the dental need. Based on the responses, the member is scheduled appropriately.
2. The questions asked serve as guidelines and are not intended to substitute for the assistance of clinical staff in making determinations. Office staff consults with clinical staff or the practitioner to determine the appropriate length of time the member's condition requires for treatment.

B. Walk-in triage
Walk-in members requesting dental care are assessed to determine if the level of care required is emergent, urgent or routine.

1. When a walk-in patient does not have an appointment, clinical personnel undertake triage. The triage process may consist of, but is not limited to:
    a. Discussion with member or family to determine nature of problem
    b. Superficial examination of affected area, if appropriate
    c. Review of member's dental record and/or dental history
    d. Assessment of needs based on discussion, examination, and review
2. If clinical personnel are unable to assess the degree of need, the dentist is consulted.

C. Appointment scheduling:

1. **Emergent dental care**: The member is seen or treated within **24 hours**. Members calling or walking into the office with emergent problems are put in immediate contact with a clinical staff member.
   If the dental condition requires treatment not available in the office, the member is sent to the appropriate facility or specialty dentist immediately. Referrals are provided if necessary.
2. **Urgent dental care:** Urgent care is made available within **one week** depending on the member's condition. Urgent calls shall be returned within 30 minutes or 60 minutes if more information is needed to determine if it's an urgent need. If the provider cannot see them within 14 days (7 days if the member is pregnant) the providers staff either makes the appropriate referral to either another participating

provider or specialist or calls ODS Dental Customer Service for a referral. Documentation is entered into the member's dental record.

3. **Routine care**: A member with routine care needs is scheduled for an appointment within an average of **eight weeks** unless there is a documented special clinical reason, which would make access longer than 8 weeks appropriate.

D. 24-Hour access: The established patient has access to a dental provider 24 hours a day, 7 days a week. If the provider is not available, they arrange coverage with another provider. If an answering machine is used for after-hours access, the message shall give specific after-hours instructions to call a number so the member has access to the provider or the on-call provider. If a member calls their provider or the on-call provider, the provider triages the situation and determines the members condition to the extent possible and either treats the member for their condition or if necessary, refers the member of a hospital emergency room.

Monitoring access

ODS Community Dental uses the following methods to monitor contracted providers to ensure timely access to care. Dentists who do not meet the criteria outlined are notified that they must comply with the rules in order to continue as a participating provider with ODS Community Dental.

1) ODS Community Dental conducts a weekly or monthly Third Next Available Appointment (TNAA) survey to assess timely access for emergent, urgent, routine care and routine care for pregnant women and urgent care for pregnant women in accordance with Oregon Administrative Rules 410-141-3515 (11)(b). Providers within the PacificSource CCO's (Central Oregon, Columbia Gorge, Lane, Marion and Polk) are required to submit data on a weekly basis while providers in other CCO's are required to report on a monthly basis.

- General and Pediatric dentistry providers must report their TNAA for each appointment type (emergent, urgent, routine, routine for pregnant women and urgent for pregnant women).
- Specialty dental providers such as Periodontists, Endodontists, Orthodontists, Oral Surgeons, and Denturists must report their TNAA for routine appointments.
- This must be completed for each OHP provider at every clinic (provider in multiple locations must report the TNAA for every location)
- If a provider is not meeting access standards, they must report special circumstances or reasons that are temporarily limiting their availability (provider out of office, illness, staffing changes, clinic construction, etc.

2) ODS Community Dental conducts an after-hour telephone survey to assess timely access of our members for appointments and 24-hour access, 7 days a week for dental emergencies in accordance with the following rules:

- Oregon Administrative Rule 410-141-3840 and 410-141-3515 (11)(b)(A) for the Oregon Health Plan
- Board of Dentistry's rule 818-012-0010 under "Unacceptable Patient Care"

These rules require that we provide or arrange for emergency treatment for established patients.

We conduct the after-hours survey between 6 p.m. and 7 a.m. to identify what type of coverage is in place. We expect the dentist will have one of the following:

- An answering service that is able to reach the patient's primary dentist or an on-call dentist; or
- The patient's primary dentist office message will instruct an established patient to call a listed after-hours telephone number to reach the primary dentist or an on-call dentist. We also call this after-hours number to determine whether the patient can leave a message.
- If a provider is not meeting the standard, they are notified by ODS and must provide a plan to gain compliance. A follow-up survey is conducted within 2 months. If non-compliance continues, it is reported to Dental Quality Improvement Committee, which may recommend removal from ODS Community Panel.

3) ODS Community Dental audits contracted provider dental records on an annual basis to ensure compliance with the Oregon Board of Dentistry Oregon Administrative Rule (OAR) 818-012-0070 standards of practice for patient records, and to evaluate quality of care, access to care and ongoing performance improvement.

- ODS will select a random sample of records to review and will submit request to providers.
- The list of items to be reviewed during each chart audit is evaluated annually by ODS' Dental Director to ensure it meets current standards of practice for dental records. To assess timely access to care, providers must submit appointment scheduling proof.
- Each dental record is reviewed by a qualified reviewer and scored for completeness.
- Providers are notified of the results. Any charts that fall below the passing score are reported to the Dental Quality Committee for appropriate interventions.

MEMBER RIGHTS AND RESPONSIBILITIES

Members can find a copy of these rights and responsibilities in the Dental Member Handbook they receive upon enrollment.

Member rights

As a member of ODS Community Dental, you have the right to:

1. Be treated with dignity and respect; and with consideration for your privacy;
2. Have providers that treat you the same as they would treat other people looking for health care benefits;
3. Pick or change your dentist;

4. Refer yourself directly to mental health, chemical dependency or family planning services without a referral from a provider.
5. Have a friend, family member or advocate with you during appointments or other times needed within clinical guidelines;
6. Be actively involved in making your treatment plan;
7. Be given information about your condition and covered and non-covered services. This is so you can make an informed decision about proposed treatments.
8. Consent to treatment or refuse services and be told what will happen because of that decision, except for court ordered services;
9. Get written documents about your rights, benefits, how to access services, and what to do in an emergency;
10. Have written materials explained in a way that you understand. This includes education on how coordinated care works and services in the coordinated health care system;
11. Get help getting the cultural and linguistic care you need in places as close as possible to where you live or seek services; and pick providers that are in non-traditional settings, if available in the network, that are accessible to families, diverse communities, and underserved populations;
12. Get oversight, care coordination, transition and planning management from ODS to ensure culturally and linguistically appropriate community-based care is provided in the best way for you.
13. Get the services needed to diagnose your conditions;
14. Get integrated, person-centered care and services that provide choice, independence, and dignity; and meet generally accepted standards of practice and are medically appropriate.
15. Have a consistent and stable relationship with a team that manages your care;
16. Get help navigating the health care delivery system and accessing community and social support services, and statewide resources. This includes but is not limited to the use of certified or qualified health care interpreters, certified traditional health care workers including community health workers, peer wellness specialists, doulas, and personal health navigators who are part of your care team to provide cultural and linguistic help you need to access appropriate services and participate in processes affecting your care and services.
17. Get covered preventive services;
18. Access urgent and emergency services 24 hours a day, seven days a week without prior authorization;
19. Get a referral to specialty providers for appropriate covered services;
20. Have a clinical record that lists conditions, services received, and referrals made;
21. Have access to your own clinical record, unless restricted by statute;
22. Send a copy of your clinical record to another provider;

23. Have your clinical record corrected or changed to be more accurate;
24. Write a statement of wishes for treatment. This includes the right to accept or refuse medical, surgical, dental, or behavioral health treatment, and the right to execute directives and powers of attorney for health care established under ORS 127;
25. Get written notices before a denial of, or change in, a benefit or service level is made, unless a notice is not required by federal or state regulations;
26. Be able to make a complaint or appeal with ODS and receive a response;
27. Ask for an administrative hearing;
28. Get free and qualified or certified health care interpreter services; including sign language interpretation;
29. Get told in a timely manner if your appointment will be cancelled;
30. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion
31. Be treated fairly and file a complaint of discrimination if you feel you have been treated unfairly because of your age, color, disability, gender identity, marital status, race, religion, sex, or sexual orientation;
32. Share information with ODS electronically if you wish to.

Member responsibilities

As an ODS Community Dental member, it is your responsibility to:

1. Help choose a dentist if needed;
2. Treat all ODS Community dental staff, providers, and clinic staff with respect;
3. Be on time for your appointments;
4. Call ahead of time to cancel an appointment and call ahead if you expect to miss or will be late to your appointment;
5. Seek periodic health exams and preventive care from your primary care dentist (PCD);
6. Use your PCD or clinic for diagnostic and other care;
7. Get a referral to a specialist from your PCD before seeking care from a specialist, unless self-referral is allowed;
8. Use urgent and emergency services appropriately and notify ODS within 72 hours of using emergency services in the manner provided by ODS' referral policy;
9. Give accurate information for your clinical record so providers can give you the best care;
10. Help your provider get clinical records from other providers, which may include signing an authorization for release of information;

11. Ask questions about conditions, treatments and other issues related to your care that you do not understand;
12. Use information provided by ODS providers and care teams to make informed decisions about treatment before it is given;
13. Help in the creation of a treatment plan with your provider;
14. Follow prescribed, agreed-upon treatment plans and actively engage in your healthcare;
15. Tell providers that your healthcare is covered under the Oregon Health Plan before you get services; and if your provider asks for it, show them your Oregon Health ID card;
16. Call OHP Customer Service to tell them if:
    a. You change your address or phone number
    b. You become pregnant and when the baby is born
    c. Any family members move in or out of your household
    d. You have any other insurance available
17. Pay for non-covered services
18. Pay any monthly OHP premium on time if required
19. Help your ODS get any third-party resources available and reimburse ODS the amount of benefits it paid for an injury from any recovery received from that injury.
20. Bring issues, complaints, or grievances to the attention of ODS.

SECLUSION AND RESTRAINT POLICY

In accordance with Federal law, we recognize that each patient has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

A ***restraint*** is (a) any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or (b) a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.

Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff members or others from harm. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm. In addition, the nature of the restraint or seclusion must take into consideration the age, medical and emotional state of the patient. Under no circumstances may an

individual be secluded for more than one (1) hour.

The use of restraint or seclusion must be implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by this policy and in accordance with applicable state law. In addition, the use of restraint or seclusion must be in accordance with the order of a physician or other licensed health care professional who is responsible for the care of the patient.

ODS Community Dental requires their participating dentists to have a policy and procedure regarding the use of seclusion and restraint as required under the Code of Federal Regulations and also requires the provider to provide ODS a copy of their policy upon request.

(42 CFR, 438.100, be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation)

MEMBER DISMISSAL AND DISENROLLMENT GUIDELINES

Definitions:

- Dismissal is when a member is removed from the care of their general dentist.
- Disenrollment is when a member is removed from their OHP dental plan.

Requirements:

ODS Community Dental must follow the guidelines established by the Oregon Heath Authority's Health Systems Division regarding disenrolling members from the plan. ODS Community Dental encourages members and their providers to resolve complaints, problems and concerns at the clinic level.

Key points when considering member dismissal:

In general, the key requirements when considering dismissing a member include:

- Timely, early communication
- Thorough documentation of events, problems and behaviors
- A plan generated by the dental office to attempt to address the problem or concern
- Use of contracts and case conferences
- Consideration of mental health diagnoses whenever dismissing or requesting disenrollment of a member

When can a member be dismissed?

A member may be dismissed from a dentist's office or disenrolled from ODS Community Dental only with just cause. The list of just causes, identified by Health Systems, includes but is not

limited to:

- Missed appointments
- Drug-seeking behavior
- Committing or threatening an act of physical violence directed at a dental provider, office staff, clinic, property, other patients, or ODS Community Dental staff
- Dismissal from dentist by mutual agreement between the member and the provider
- Agreement between provider and ODS Community Dental that adequate, safe and effective care can no longer be provided
- A fraudulent or illegal act committed by a member, such as permitting someone else to use their OHP Medical ID Card, altering a prescription, or committing a theft or another criminal act on any provider's premises

When you decide to dismiss a member:

When you and your clinic decide to dismiss a member you must send a letter to the member informing them of the dismissal, with a copy to ODS Community Dental. Dentists are asked to provide urgent care for the dismissed member for 30 days following this notification. ODS Community Dental customer service representatives work with the member to establish a new dentist.

When a member cannot be dismissed:

Oregon Administrative Rule 410-141-3810 (4)© states that members shall not be dismissed from a dentist or disenrolled from ODS Community Dental solely because:

- The member has a physical, intellectual, developmental, or mental disability.
- There is an adverse change in the member's health.
- The provider or ODS Community Dental believes the member's utilization of services is either excessive or lacking.
- The member requests a hearing against a provider or ODS Community Dental.
- The member exercises their option to make decisions regarding their dental care, with which the provider or the plan disagrees.
- The member engages in uncooperative or disruptive behavior as a result of their special needs.

Causes for requesting member disenrollment:

ODS Community Dental requests immediate disenrollment when notified about any of the following circumstances:

- Disruptive, unruly or abusive behavior.
- The member commits a fraudulent or illegal act, such as permitting someone else to use their Medical ID Card, altering a prescription, or committing a theft or another criminal act on any provider's premises.
- The member commits or threatens an act of physical violence directed at a dental provider, office staff, property, clinic, other patient, or ODS Community Dental staff.
- Missed appointments.

Send copies of relevant documentation, including chart notes and a police report, to ODS Community Dental. ODS Community Dental will contact Health Systems to request immediate disenrollment.

MISSED APPOINTMENT POLICY

We ask that you establish an office policy for the number of appointments you will allow a member to miss before dismissing them from your practice. This policy should apply equally for all patients. You must notify members of this policy on their first visit and have them sign an acknowledgement of the policy.

When a member misses an appointment, you should contact the member to reschedule and document the missed appointment. If the member continues to miss appointments and you decide to dismiss the member, you must send a letter to the member informing them of the dismissal and provide a copy to ODS Community Dental Case Management or send completed Missed Appointment form located online at: https://www.odscommunitydental.com/providers/resources/missed-appointment-form.

Please include other relevant documents including chart notes, correspondence sent to the member, signed contracts and/or documentation of case conferences. We will ask the member to select a new provider. After a member has been dismissed from two providers within a 12-month period for missing appointments, we will request that the member be disenrolled from ODS Community Dental.

MEMBER COMPLAINTS AND APPEALS

Complaints

A complaint is an expression of dissatisfaction to ODS Community Dental or a provider about

any matter that does not involve a denial, limitation, reduction, or termination of a requested covered service. Examples of complaints include, but are not limited to access to providers, waiting times, demeanor of dental care personnel, quality of care and adequacy of facilities.

We encourage you to try to resolve member complaints on your own. If you cannot resolve a complaint, please inform the member that ODS Community Dental does have a formal complaint procedure. Members can contact our customer service department to make a complaint. If a member isn't satisfied with the way we handle a complaint the member can file a complaint with the Oregon Health Authority's Ombudsman's Office. There is no time limit for filing a complaint.

A member may also file a complaint directly with the state of Oregon:

Oregon Health Authority
Ombudsperson 500 NE Summer St. NE, E17
Salem, OR 97310-1097
Phone: 503-947-2346 or 877-642-0450 (TTY: 711)

Members have the right to have a representative (including their provider) file a complaint on their behalf. The member's written consent is required in order to file a grievance or appeal on the member's behalf.

Appeals

An appeal is a request to review an ODS Community Dental decision to deny, limit, reduce or terminate a requested covered service or to deny a claim payment. It can be made by a member, the member's representative, or a provider as long as the person appealing has the member's permission. Member appeals must be within 60 days of the decision to deny or limit services.

They also have the right to file a request for an administrative hearing with the Oregon Health Authority. The member has the right to request that the benefits continue while the case is being decided, however if the decision to terminate or limit benefits is upheld the member will be required to pay for services performed during the appeal.

An appeal may be requested as follows:

Write
Member Appeal
Unit ODS
Community Dental
P.O. Box 40384
Portland, OR 97240

Fax
503-412-4003

Telephone
ODS Community Dental OHP:
503-243-2987 or 800-342-0526
(TTY 711)

Resolving Complaints and Appeals

The ODS Community Dental appeals staff makes decisions about member complaints and appeals, seeking input from appropriate parties, such as the provider, dental consultant, or care coordination staff. Most complaints are resolved within five days, and most appeals are resolved within 16 days, but for more complicated complaints and appeals it may take up to 30 days to resolve.

If a member is experiencing an emergency and cannot wait for a review, they may call or write to ODS and ask for an expedited appeal. If the appeal is an emergency, we will respond to the request within 72 hours.

If ODS fails to adhere to the notice and timing requirements for extension of the appeal resolution timeframe, the member may initiate a contested case hearing.

Contested care hearing process

OHA has an appeal process for members who are dissatisfied with our response to an appeal of a denial, limitation, reduction or termination of a requested covered service or denial of claims payment. This process is outlined in the ODS Notice of Adverse Benefit Determination letter.

If a provider filed an appeal on behalf of a member, the provider may subsequently request a contested case hearing on behalf of the member with the member's written consent, in accordance with the procedures in OAR 410-141-3900.

Members may obtain more information about this process by contacting their OHP caseworker or by contacting the ODS Community Dental customer service department at 800-342-0526.

OHP Complaint Form

A member may file a complaint using an OHP Complaint Form 3001 and an appeal using a Request for Administrative Hearing (MSC 443) or Appeal and Hearing Request for Medical Service Denials (OHP 3302). These forms can be found online. Complaint forms are also available on the ODS website.

Denials

When ODS Community Dental denies a service or referral, the provider is notified, and a notice of adverse benefit determination is mailed to the member. The notice includes the following information:

- Service requested
- Reason for denial
- Member's appeal rights and instructions
- Member's right to file an OHP administrative hearing request and instructions

SUBMITTING CLAIMS

Acceptable Claim Form

Please file all claims using the most recent American Dental Association Dental Claim form. If you would like information on billing claims electronically, contact our Dental PR department at 888-374-8905 or 503-265-5720.

Timely filing guidelines

ODS Community Dental requests that you submit all eligible claims within four months from the date of service. We will consider claims received after this invalid and won't pay them. There are exceptions, you must submit claims that meet the criteria outlined in OAR 410-141-3565 within 12 months of the date of service or we will consider them invalid and won't pay them.

Use your proper provider identifiers

In order for claims to be processed correctly, each claim must include the correct Tax ID Number (TIN), license number and National Provider Identifier (NPI). If your clinic has multiple dentists or providers, the name of the individual who provided the service must also be noted. If this information is not provided, the claim may be returned for resubmission with the missing information

If you do not receive an explanation of payment (EOP) within 45 days after you submit the claim, your billing office should contact ODS Community Dental Customer Service or check Benefit Tracker to verify that we have received the claim. Please verify that we have received your initial claim before you submit a duplicate. When submitting a claim electronically, please check the error report from your vendor to verify that all claims have been successfully sent. Lack of follow-up may result in the claim being denied for lack of timely filing.

You must submit all information to process a claim in a timely manner (e.g., radiographs, chart notes). You must identify adjustments and make those requests within 12 months of the date of service.

Corrected Billings

To make corrections to a previously submitted claim, please write "corrected billing" in the remarks section of a paper claim or note "corrected billing" on an electronic claim. In addition, please include dental records if the change involves a change in procedure or the addition of procedure codes.

ELECTRONIC CLAIMS SUBMISSION

You can reduce administrative time and shorten turnaround time by submitting claims electronically. We can accept claims from the following electronic connections:

- DMC (Dentist Management Corporation)
- APEX EDI
- CPS (Claims Processing System)
- EHG (EDI Health Group, Inc.)
- TESIA/PCI Corp.
- QSI (Quality System Incorporated)

Our EDI Department will work with your office to advise you of the options available.

For information on setting up this process, please call or write:
Moda Health EDI Department
601 SW Second Ave. Portland, OR 97204

888-784-7954800-852-5195

Email: edigroup@modahealth.com

MEMBERS WITH OTHER INSURANCE COVERAGE

OHP is secondary to other insurance coverage. If the member has private insurance, that carrier's Explanation of Benefits (EOB) should be submitted with the claim as soon as the EOB is received. Exceptions to this rule include members who have Indian Health Services, Tribal Health Facilities and Veterans Administration plans.

Calculating coordination of benefits

As secondary payer, ODS Community Dental issues benefits when the primary carrier paid less than our allowed amount for each procedure. We pay the difference between the amount we allow and the primary carrier's total payment.

If the primary plan pays more than our allowed amount, we will not issue a benefit. All remaining balances, including primary plan deductibles and/or co-insurances, are to be included in the provider discount.

PREDETERMINATION OF BENEFITS

Predeterminations are always optional and never required for any dental services and are not guarantee of payment. For a complete list of services that are eligible for predeterminations,

please refer to our comprehensive list of covered and non-covered services. This list includes detailed CDT code benefit information including any age or frequency limitations, as well as predetermination option availability. You can find this list on the ODS Community Dental website at www.odscommunitydental.com. Select dental provider, resources, forms and then OHP forms.

Predeterminations are an option for partials, dentures, and surgical third molar extractions. A current ADA form may be submitted with the following information:

- The request for predetermination box at the top of the form should be checked
- The appointment date fields should be blank
- Use current ADA codes for all proposed procedures

Care coordination is important to us. If you have a Medicaid patient with a healthcare need or comorbid condition that requires them to have additional dental treatments please send a letter and supporting chart notes to our dental team at https://www.odscommunitydental.com/providers/resources/dental-provider-correspondence-request-form .

PRIOR AUTHORIZATION

A Prior Authorization is a required payment authorization for specified dental services that must be obtained prior to the provision of the service. ODS Community Dental only requires Prior Authorization for the following CDT codes: D8080, D8220, D8680, D8695

PROFESSIONAL REVIEW

The professional review department reviews selected claims to determine if a service is necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury. When we select a claim for review, we will notify you by letter. You can then send in the clinical, referencing the claim number on the letter. It is important to send the recommended information and ensure your radiographs are of diagnostic quality and clearly labeled with date of exposure to expedite the process.

By selecting claims randomly and based on practice and billing patterns (focused review), we are able to reduce the number of codes requiring 100 percent review. Supporting documentation such as radiographs are usually needed on only a portion of all claims, and we recommend reviewing the following sections Professional Review Procedure Codes and Clinical Review Requirements for specific clinical submission guidelines.

We handle your re-evaluation requests in the same manner; however, we do not re-evaluate claims without additional, pertinent information.

ODS Community Dental's Practice Guideline policy can be viewed at ODScommunitydental.com.

Procedure codes that ALWAYS require professional review

The following list of procedure codes will always go through the professional review process, requiring clinical documentation for benefit determination.

To expedite the processing of your claim, please submit the clinical information with your initial claims submission using the clinical review requirements on the following pages:

Restorative	Endodontics	Periodontics	Prosthodontics	Oral & Maxillo-facial Surgery	Orthodontia	Adjunctive General Services
D2751	D3331	D4920	D5211	D7287	D8080	D9211
D2752	D3351		D5212	D7340	D8220	D9212
D2980	D3352		D5221	D7350	D8680	D9630
			D5222	D7287	D8695	
				D7340		
				D7350		
				D7540		
				D7550		
				D7560		
				D7670		
				D7911		
				D7912		

CLINICAL INFORMATION REQUIREMENTS

Please refer to the *Professional 100% Review Procedure Codes* list in this handbook for a list of procedure codes that will ALWAYS require documentation for payment determination. Information provided below includes codes that are not on the 100% review list. The submission request information is for your office to use as a guideline in the event a claim is randomly selected for professional review.

The below requirements are necessary for our professional review team to adequately determine necessity. Chart notes should always include diagnosis and justification for all treatment rendered.

DIAGNOSTIC SERVICES: D0100-D0999		
Code	Description of service	Submission request
D0140	Limited Oral Evaluation – Problem Focused	Chart notes outlining the necessity of the treatment rendered, including the diagnosis for the below dates of service(s). Include any additional diagnostic information available to assist in determining benefits.
D0220, D0230	Periapical Radiographs	Current periapical radiographs, including diagnosis, chart notes outlining the necessity of the treatment rendered, including the diagnosis. Include any additional diagnostic information available to assist in determining benefits.
D0310	Sialography	Chart notes outlining the necessity of the treatment rendered, including the diagnosis. Include any additional diagnostic information available to assist in determining benefits.
D0321	Temporomandibular Joint Films	Chart notes outlining the necessity of the treatment rendered, including the diagnosis. Include any additional diagnostic information available to assist in determining benefits.
CROWNS D2390 - D2980		
Code	Description of Service	Submission Request
D2390	Resin-based composite crown, anterior	Current periapical radiographs with detailed, tooth specific chart notes regarding the necessity of the treatment and any available photograph. We request that you not substitute a panoramic type radiograph if periapical radiographs are available.
D2710, D2712, D2740, D2751, D2752	Crowns – single restorations only	Current periapical radiographs with detailed, tooth specific chart notes regarding the necessity of the treatment and any available photograph. We request that you not substitute a panoramic type radiograph if periapical radiographs are available.

D2980	Crown Repair	Current periapical radiographs with detailed, tooth specific chart notes regarding the necessity of the treatment and any available photograph. We request that you not substitute a panoramic type radiograph if periapical radiographs are available.
BUILDUP/POSTS: D2950 - D2957		
Code	Description of Service	Submission Request
D2950, D2951, D2954, , D2957	Core buildup for single restorations	Current periapical radiographs with detailed chart notes regarding the necessity of the treatment and preoperative photograph. We request that you not substitute a panoramic type radiograph if periapical radiographs are available. Please also indicate the type of final restoration being placed after completion of the endodontic treatment. If replacement crown, periapical radiographs and/or photos after existing crown removed, Per the ADA, buildups should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation.
ENDODONTICS: APEXIFICATION D3310-D3353		
Code	Description of Service	Submission Request
D3310, D3320, D3330	Endodontic Therapy	Pre-operative and post-operative periapical radiographs, if applicable, with chart notes regarding the necessity of the endodontic procedure. Please also indicate the type of final restoration being placed after completion of the endodontic treatment.
D3331, D3333	Obstruction and root repair	Pre-operative and post-operative periapical radiographs, if applicable, with chart notes regarding the necessity of the endodontic procedure.
D3332	Incomplete root canal	Please provide chart notes indicating why this tooth is inoperable or unrestorable.

D3346	Retreatment of Previous Root Canal Therapy – anterior	Current periapical radiographs and chart notes. Please also indicate the type of final restoration being placed after completion of the endodontic treatment.
D3351, D3352, D3353	Apexification/recalcification procedures	Please provide chart notes and current periapical radiographs, including diagnosis
PERIODONTAL PROCEDURES: D4210-D4920		
Code	Description of Service	Submission Request
D4210, D4211	Gingivectomy	Periodontal charting (probing done within past 12 months), diagnosis, bitewing radiographs, and chart notes regarding the necessity of the periodontal treatment, and date of last active periodontal therapy, if applicable.
D4341, D4342	Periodontal scaling and root planning	Periodontal charting (probing done within past 12 months), diagnosis, bitewing radiographs, and chart notes regarding the necessity of the periodontal treatment, and date of last active periodontal therapy, if applicable.
D4910	Periodontal maintenance	Periodontal charting (probing done within past 12 months), diagnosis, bitewing radiographs, and chart notes regarding the necessity of the periodontal treatment, and date of last active periodontal therapy, if applicable.
D4355	Full-mouth debridement to enable comprehensive evaluation and diagnosis	Chart notes regarding necessity, and any additional diagnostic information to assist in determining benefits.
D4920	Unscheduled dressing change	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
PROSTHETICS: D5211 – D5821		
Code	Description of Service	Submission Request
D5211, D5212, D5221 D5222	Removable prosthetic services	Current periapical radiographs, periodontal charting done within past 12 months and definitive treatment plan for entire mouth. Please indicate missing teeth to be replaced and teeth to be clasped, as well as any additional teeth that will be extracted.

D5820, D5821	Interim Partial Denture	Current periapical radiographs, periodontal charting done within past 12 months, definitive treatment plan for entire mouth and chart notes.
BIOPSY: D7285-D7465		
Code	Description of Service	Submission Request
D7285, D7286, D7287, D7288, D7410, D7440, D7450, D7460, D7465	Surgical procedures	Pathology report indicating specific location of tissue. Services performed on the lip, cheeks or tongue are not covered.
ORAL AND MAXILLOFACIAL SURGERY: D7111- D7997 (EXCLUDING BIOPSY)		
Code	Description of Service	Submission Request
D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7490, D7510, D7530, D7540, D7550, D7560, D7961, D7962 D7963, D7971	Oral and maxillofacial surgery	Current periapical radiographs and chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
D7320, D7340, D7350, D7471, D7520, D7670, D7770, D7910, D7911, D7912, D7970, D7980, D7981, D7982, D7983, D7990, D7997	Oral and maxillofacial surgery	Chart notes outlining the necessity of the treatment rendered, including the diagnosis. Please include any additional diagnostic information available to assist in determining benefits.
ORTHODONTIA: D8080-D8695		
Code	Description of Service	Submission Request

D8080,D8220, D8680, D8695	Orthodontia	Chart notes, current panoramic and cephalometric radiographs, intraoral and extraoral photographs, including diagnosis and reason treatment is medically necessary. Please also include a completed Handicapping Labio-Lingual Deviation Scoresheet.
ADJUNCTIVE PROCEDURES: D9910- D9940		
Code	Description of Service	Submission Request
D9211, D9212, D9310, D9211, D9212, D9310, D9440, D9610, D9612, D9630, D9920, D9930	Adjunctive procedures	Chart notes outlining the necessity of the treatment rendered, including the diagnosis. Please include any additional diagnostic information available to assist in determining benefits.

Information required only when clinical is requested.

Photographs are always beneficial in determining cracked teeth, build-ups, crowns, and anterior restorations.

FRAUD AND ABUSE

ODS Community Dental policy requires that its employees and providers comply with all applicable provisions of federal and state laws and regulations regarding the detection and prevention of fraud, waste and abuse in the provision of health care services to ODS Community Dental members and payment for such services to providers. Complete descriptions of the applicable federal and state laws are listed at the bottom of this policy.

Two common types of healthcare fraud include member and provider fraud.

Examples of member fraud include:

- Using someone else's coverage or allowing someone other than the member to use the member's insurance card or coverage to receive treatment
- Filing for claims or medications that were never received
- Forging or altering bills or receipts

Examples of provider fraud include:

- Billing for services or procedures that were not provided
- Performing medically unnecessary services in order to obtain insurance reimbursement

- Incorrect reporting or unbundling of procedures or diagnoses to maximize insurance reimbursement
- Misrepresentations of dates, description of services or subscribers/providers

To ensure that you are not the victim of healthcare fraud:

- Always ask for photo identification of new patients. Make a copy and put it in their chart. If you are able to take a photo of your patients, do so.
- Make sure to have a signature on file in the patient's handwriting.
- Thoroughly check the EOP that ODS Community Dental sends you. Make sure that the dates, patient and services are correct. Also, make sure this was an appointment the patient actually attended — it is common for criminals to bill for services not received and ask for the payment to be sent to them.

ODS Community Dental has a fraud, waste and abuse prevention, detection and reporting that applies to all ODS Community Dental employees and providers. We also have internal controls and procedures designed to prevent and detect potential fraud, waste and abuse by groups, members, providers and employees.

This plan includes operational policies and controls in areas such as claims, predeterminations, utilization management and quality review, member complaint and grievance resolution, practitioner credentialing and contracting, ODS Community Dental employee and provider education, human resource policies and procedures, and corrective action plans. Verified cases of fraud, waste or abuse are reported to the appropriate regulatory agency. ODS Community Dental reviews and revises its fraud and abuse policy and operational procedures annually.

If you suspect you are the victim of fraud or if you suspect a member is committing fraud, please call ODS Community Dental immediately at 877-372-8356. We will investigate all reports of fraud to protect our providers and members.

Information obtained as part of a suspected fraud, waste or abuse investigation may be considered confidential. Any information used and/or developed by participants in the investigation of a potential fraud, waste and abuse occurrence is maintained solely for this specific purpose. ODS Community Dental assures the anonymity of complainants to the extent permitted by law.

Federal laws

False Claims Act: The federal civil False Claims Act (FCA) is one of the most effective tools used to recover amounts improperly paid due to fraud and contains provisions designed to enhance the federal government's ability to identify and recover such losses. The FCA prohibits any individual or company from knowingly submitting false or fraudulent claims, causing such claims to be submitted, making a

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false record or statement in order to secure payment from the federal government for such a claim, or conspiring to get such a claim allowed or paid. Under

the statute, the terms “knowing” and “knowingly” mean that a person (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. Examples of the types of activity prohibited by the FCA include billing for services that were not actually rendered, and upcoding (billing for a more highly reimbursed service or product than the one actually provided).

The FCA is enforced by the filing and prosecution of a civil complaint. Under the Act, civil actions must be brought within six years of a violation or, if brought by the government, within three years of the date when material facts are known or should have been known to the government, but in no event more than 10 years after the date on which the violation was committed. Individuals or companies found to have violated the statute are liable for a civil penalty for each claim of not less than $5,500 and not more than $11,000, plus up to three times the amount of damages sustained by the federal government.

Qui tam and whistleblower protection provisions: Qui tam is a unique mechanism in the law that allows citizens to bring actions in the name of the United States for false or fraudulent claims submitted by individuals or companies that do business with the federal government. A qui tam action brought under the FCA by a private citizen commences upon the filing of a civil complaint in federal court. The government then has 60 days to investigate the allegations in the complaint and decide whether it will join the action. If the government joins the action, it takes the lead role in prosecuting the claim.

However, if the government decides not to join, the whistleblower may pursue the action alone, but the government may still join at a later date. As compensation for the risk and effort involved when a private citizen brings a qui tam action, the FCA provides that whistleblowers who file a qui tam action may be awarded a portion of the funds recovered (typically between 15 and 25 percent), plus attorneys’ fees and costs.

Whistleblowers are also offered certain protections against retaliation for bringing an action under the FCA. Employees who are discharged, demoted, harassed or otherwise encounter discrimination as a result of initiating a qui tam action or as a consequence of whistle blowing activity are entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay with interest and compensation for any special damages, including attorneys’ fees and costs of litigation.

Federal Program Fraud Civil Remedies Act: The Program Fraud Civil Remedies Act of 1986 provides for administrative remedies against people who make, or cause to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services. Any person who makes, presents or submits, or causes to be made, presented or submitted, a claim that the person knows or has reason to know is false, fictitious or fraudulent is subject to civil money penalties of up to $5,000 per false claim or statement and up to twice the amount claimed in lieu of damages. Penalties may be recovered through a civil action or through an administrative offset against claims that are otherwise payable.

State laws

Public assistance: Under Oregon law, no person shall obtain or attempt to obtain, for personal benefit or the benefit of any other person, any payment for furnishing any need to or for the benefit of any public assistance recipient by knowingly: (1) submitting or causing to be submitted to the Department of Human Services any false claim for payment; (2) submitting or causing to be submitted to the department any claim for payment that has been submitted for payment already unless such claim is clearly labeled as a duplicate; (3) submitting or causing to be submitted to the department any claim for payment that is a claim upon which payment has been made by the department or any other source unless clearly labeled as such; or (4) accepting any payment from the department for furnishing any need if the need upon which the payment is based has not been provided. Violation of this law is a Class C felony.

Anyone who accepts from the Department of Human Services any payment made to such person for furnishing any need to or for the benefit of a public assistance recipient shall be liable to refund or credit the amount of such payment to the department if such person has obtained or subsequently obtains from the recipient or from any source any additional payment received for furnishing the same need to or for the benefit of such recipient.
However, the liability of such person shall be limited to the lesser of the following amounts: (a) the amount of the payment so accepted from the department; or (b) the amount by which the aggregate sum of all payments so accepted or received by such person exceeds the maximum amount payable for such need from public assistance funds under rules adopted by the department.

Anyone who, after having been afforded an opportunity for a contested case hearing pursuant to Oregon law, is found to violate ORS 411.675 shall be liable to the department for triple the amount of the payment received as a result of such violation.

False claims for healthcare payments: A person commits the crime of making a false claim for healthcare payment when the person: (1) knowingly makes or causes to be made a claim for healthcare payment that contains any false statement or false representation of a material fact in order to receive a healthcare payment; or (2) knowingly conceals from or fails to disclose to a healthcare payer the occurrence of any event or the existence of any information with the intent to obtain a healthcare payment to which the person is not entitled, or to obtain or retain a healthcare payment in an amount greater than that to which the person is or was entitled. The district attorney or the attorney general may commence a prosecution under this law, and the Department of Human Services and any appropriate licensing boards will be notified of the conviction of any person under this law.

Whistleblowing and non-retaliation: ODS Community Dental may not terminate, demote, suspend or in any manner discriminate or retaliate against an employee with regard to promotion, compensation or other terms, conditions or privileges of employment if the employee has in good faith reported fraud, waste or abuse by any person, has in good faith caused a complainant's information or complaint to be filed against any person, has in good faith cooperated with any law enforcement agency conducting a criminal investigation into allegations of fraud, waste or abuse, has in good faith brought a civil proceeding against an employer or has testified in good faith at a civil proceeding or criminal trial.

Racketeering: An individual who commits, attempts to commit, or solicits, coerces or intimidates another to make a false claim for healthcare payment may also be guilty of unlawful

racketeering activity. Certain uses or investment of proceeds received as a result of such racketeering activity is unlawful and is considered a felony.

CONFIDENTIALITY

Confidentiality of member information is extremely important. All healthcare providers who transmit or receive health information in one of the Health Insurance Portability and Accountability Acts (HIPAA) transactions must adhere to the HIPAA privacy and security regulations. There may be state and federal laws that provide additional protection of member information.

You must offer privacy and security training to any staff that have contact with individually identifiable health information. All individually identifiable health information contained in the medical record, billing records or any computer database is confidential, regardless of how and where it is stored. Examples of stored information include clinical and financial data in paper, electronic, magnetic, film, slide, fiche, floppy disk, compact disc or optical media formats.

You many disclose health information contained in dental or financial records only to the patient or the patient's personal representative—unless the patient or the patient's personal representative authorizes the disclosure to some other individual (e.g., family members) or organization. The permission to disclose information and what information may be disclosed must be documented by verbal or written authorization. You may disclose health information to other providers involved in caring for your patient without the patient's or patient's personal representative's written or verbal permission. Patients must have access to, and be able to obtain copies of, their dental and financial records from the provider as required by federal law.

You many disclose information to insurance companies or their representatives for the purposes of quality and utilization review, payment or medical management. You may release legally mandated health information to the state and county health divisions and to disaster relief agencies when proper documentation is in place.

All healthcare personnel who generate, use or otherwise deal with individually identifiable health information must uphold the patient's right to privacy. You must not discuss patient information (financial as well as clinical) with anyone who is not directly involved in the care of the patient or involved in payment or determination of the financial arrangements for care. Employees (including physicians) shall not have unapproved access to their own records or records of anyone known to them who is not under their care.

Confidentiality of Protected Health Information: ODS Community Dental and provider each acknowledge that it is a "Covered Entity," as defined in the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164) adopted by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Rule"). Each party shall protect the confidentiality of Protected Health Information (as defined in the Privacy Rule) and shall otherwise comply with the requirements of the Privacy Rule and with all other state and federal laws governing the confidentiality of medical information.

ODS Community Dental staff adheres to HIPAA-mandated confidentiality standards. This is a

summary of how we protect members' health information:

- ODS Community Dental has a written policy to protect the confidentiality of health information.
- Only employees who need to access a member's information in order to perform their job functions are allowed to do so.
- Disclosure outside the company is permitted only when necessary to perform functions related to providing coverage and/or when otherwise allowed by law.
- All health information is protected regardless of its format: oral, written or electronic
- Documentation is stored securely in electronic files with designated access.

RELEASE OF INFORMATION

Information about a member's health condition, care, treatment, records, or personal affairs may not be discussed with anyone unless the reason for the discussion pertains to treatment, payment, or plan operations. If this information is requested for other reasons, the member, or the member's healthcare representative, must have completed an authorization form allowing the use or release of the member's protected health information (PHI). This form shall be signed by the patient or their personal representative and must be provided to ODS Community Dental for their records.

Release forms require specific authorization from the patient to disclose information pertaining to HIV/AIDS, mental health, genetic testing, drug/alcohol diagnosis, or reproductive health.

For your convenience, a current authorization form, and instructions for completing the form, can be downloaded from the ODS Community Dental Member Resources webpage at PHI disclosure form (April 2021) (odscommunitydental.com). This form is available in English and Spanish.

QUALITY IMPROVEMENT

Program goal

At ODS Community Dental, the goal of our quality improvement (QI) program is to ensure timely access and delivery of appropriate, cost-effective, and high-quality oral healthcare to our members.

Program objectives

- Implement review processes to evaluate dental aspects of care, such as:
  - Utilization of services
  - Appropriateness of care
  - Adequacy of dental record keeping
  - Operation and outcome of referral process
  - Access (the appointment system, after-hours call-in system, etc.)
  - Grievance system
  - Encounter data management
  - Credentialing/Recredentialing
- Continuously evaluate and identify opportunities for improving:
  - The quality and safety of dental care and service delivery
  - Barriers to services at the plan and practitioner level
  - Communication within the organization, and between the organization and its practitioners and members
  - Member care (experience and satisfaction) through communication of QI activities to members and practitioners
  - Collaboration with community partners
- Identify and address education needs of practitioners and members
- Ensure compliance with regulatory requirements

We meet these objectives by focusing on QI projects that have a significant impact on the oral health plan members and have measurable outcomes in terms of quality of life.

QI committee

The Dental Quality Improvement Committee (DQIC) has operational authority and responsibility for the ODS Community Dental, Dental Quality Improvement Program. It reviews and evaluates the quality and appropriateness of dental care and services provided to our members and identifies barrier to services and opportunities for improvement.

Scope of service

ODS Community Dental develops an annual QI work plan that guides their work during the year. This includes the the areas and processes that will be measured and monitored. Major plan components include but are not limited to the processes involved with quality outcomes, ensuring timely access and delivery of high quality, dentally necessary, culturally and linguistically safe dental services, utilization of services member and provider satisfaction and

communications. The scope of services also includes ensuring compliance with regulatory requirements, including internal and external quality review activities for which ODS Community Dental must provide access to dental records, information systems, personnel and documentation requested by the state division of medical assistance programs and coordinated care organizations.

Member-specific or provider-specific data are considered confidential and treated according to the ODS Community Dental confidentiality and privacy policy.

DENTAL HEALTH PROMOTION AND EDUCATION

ODS Community Dental provides health promotion and education information for members and providers. Brochures and educational flyers are posted in the Resource section of the ODS Community Dental website. You may print copies of these brochures for your patients or contact the ODS Community Dental at 844-274-9124 or dentalcasemanagement@modahealth.com to order a larger quantity of these materials.

TOBACCO CESSATION

"Clinicians should identify tobacco users at each visit and intervene with those individuals who are willing to quit. — Public Health Service (PHS) Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2012 Update

We ask that you take an active part in helping members who are ready to quit tobacco to find the resources available to them. OHP members have benefits for tobacco cessation services through their OHP medical plan.

Please help your patients who use tobacco by doing the following and documenting it in the chart notes:

Ask, Advise, Assess, Assist, Refer

ASK patients about tobacco use at every visit. Implement a system in your clinic to ensure that tobacco-use status is obtained and recorded at every patient visit.

ADVISE patients on oral health conditions related to tobacco use and provide direct advise on quitting. Use clear, strong, and personalized language. For example, "Quitting tobacco is the most important thing you can do to protect your health."

ASSESS readiness to quit.

Ask every tobacco user if they are willing to quit at this time.

- If willing to quit, provide resources and assistance (go to Assist section).
- If unwilling to quit at this time, help motivate the patient:
    - Identify reasons to quit in a supportive manner
    - Build patient's confidence about quitting

ASSIST tobacco users with a quit plan:

- Set a quit date, ideally within two weeks
- Remove tobacco products from their environment
- Get support from family, friends and coworkers

REFER OHP members who are ready to quit:

- To their medical plan to arrange for quitting
- To the Oregon Tobacco Quit Line
    - Call these numbers for free from anywhere in Oregon:
      1-800-QUIT-NOW (1-800-784-8669)
      Español: 1-877-2NO-FUME (1-877-266-3863)
      TTY: 1-877-777-6534
      Or register online at: www.quitnow.net/oregon/ Español:
      www.quitnow.net/orwwegonsp/
      The Quit Line is open 24 hours a day, 7 days a week.

Providers should document any counseling and information provided in the patient's chart notes. (Sample Notation: Patient was asked if tobacco products used, the type used, was advised on related oral health conditions, asked if he/she was interested in quitting, provided assistance with developing a quit plan and referred to medical plan and Oregon quit line).

Providers should be using CDT code D1320 when providing tobacco counseling services listed above.

ODS COMMUNITY DENTAL REFERRAL REQUEST FORM

When submitting a referral request, please follow these instructions and submit all requested information via our website:
https://www.odscommunitydental.com/providers/resources/referral-form

Incomplete request forms and/or information may result in a denial of the referral. Detailed instructions by specialty, including information required for each referral type, is available below.

General instructions for the referral form:

- Verify your patient's OHP ID number and current enrollment with OHP Plus.
- Enter the most current name and address that you have on file for your patient. Please note that ODS Community Dental will send all correspondence to your patient at the address on file in the ODS Community Dental system and will notify you of an address discrepancy.
- Enter complete referring dentist/clinic information. Please include your fax number for communication purposes.
- When requesting sedation, indicate the type of sedation you are requesting, member's history of sedation, reason for the sedation request and if hospital access is needed. Please include sedation requests in the comments section of the referral form.

Pediatric

Some OHP pediatric providers have an age restriction for the members they treat. If a pediatric provider is not available for your patient, ODS Community Dental will contact you and provide a list of general dentists who are able to treat your patient comfortably.

Endodontic

Root canal therapy is now only covered in conjunction with a final restoration that is covered under the OHP plan. The following is required for completion of an endodontic referral:

- Tooth number

- Treatment plan for final restoration
- CDT code for final restoration

Oral surgery

When requesting a referral for OHP Plus members for the extraction of third molars, the following information is required for EACH tooth. Teeth must be symptomatic to be eligible for extraction:

- Tooth number
- Pain level on a scale of 1-10, with 10 the most painful
- Unusual swelling and/or bleeding
- Acute infection
- Tooth-specific chart notes
- X-ray(s), all teeth for which a referral is requested must be visible

Periodontal

Please note that OHP benefits are very limited for periodontal services. ODS Community Dental requests general dentists attempt to treat their patients for covered services such as root planning and full-mouth debridement in their office prior to requesting a specialist referral. All periodontal referrals require the following:

- History of periodontal scaling and root planning within the last two years
- Periodontal charting (pockets must be at least 5mm in two or more quadrants)

Please submit referral forms via our website:
https://www.odscommunitydental.com/providers/resources/referral-form+

FORMS, BROCHURES, AND DOCUMENT LINKS

Member Authorization

English
https://www.odscommunitydental.com/-/media/ODSCommunityDental/PDFs/Member-resources/phi_disclosure.pdf

Spanish

https://www.odscommunitydental.com/-/media/ODSCommunityDental/PDFs/Member-resources/phi_disclosure_esp.pdf

Missed appointment form

The number of missed appointments is to be established by the provider or PHP. The number must be the same for commercial members or patients. The provider must document they have attempted to determine the reason(s) for the missed appointments and to assist the OHP member in receiving services.

https://www.odscommunitydental.com/providers/resources/missed-appointment-form

Dental hospital referral

https://www.odscommunitydental.com/providers/resources/referral-form

OHA Financial Waiver

An agreement between a Client and a Provider, as defined in OAR 410-120-0000. The client agrees to pay the provider for health service(s) not covered by the Oregon Health Plan (OHP), coordinated care organizations (CCOs) or managed care plans. For the purposes of this Agreement, services include, but are not limited to, health treatment, equipment, supplies and medications.

https://www.odscommunitydental.com/odscommunitydental/-/media/odscommunitydental/pdfs/provider-resources/patient-responsibility-waiver-in-english.pdf

Interpreter request form

Interpreters are scheduled based on availability. Please request interpreters by fax, phone, or order online with our preferred vendor, Passport to Languages no less than 48 hours prior to the appointment.
https://www.odscommunitydental.com/providers/resources/interpreter-request-form

CONTACT INFORMATION

Send dental claims to:

ODS Dental Claims

PO Box 40384

Portland, OR 97240

Send complaints and appeals to:

ODS

Attn: Appeals Unit

P.O. Box 40384

Portland, OR 97240

Fax: 503-412-4003

ODS Community dental customer service:

Provides information regarding benefits, eligibility, claim status, etc.

800-342-0526

Dental professional relations:

Provides information regarding contracts and fee schedules

503-265-5720

888-374-8905

Fax: 503-243-3965

dpror@deltadentalor.com

ODS Dental Case Management:

Coordination for members with special needs and/or special treatment requests

800-274-9124

dentalcasemanagement@modahealth.com

Benefit Tracker (BT):

Provides registration and assistance for utilizing this online resource

877-337-

0651ebt@modahealth.co

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Electronic data interchange:

Provides information regarding electronic billing and NEA

503-228-6554

800-852-5195

edigroup@modahealth.com

Health Systems MMIS System and AVR

(Provides information for OHP and eligibility requirements)

MMIS: https://www.or-medicaid.gov/ProdPortal/Default.aspx

Automated Voice Response: 866-692-3864